STATE OF CONNECTICUT
STATE TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
Toll Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.state.ct.us/trb

TRB SPONSORED HEALTH PLAN OPEN ENROLLMENT FOR JANUARY 1, 2003

Health Coverage Change Requirements

This is your annual opportunity to add or cancel coverage to your health insurance options through CTRB. If you are adding or dropping coverage, complete the enclosed form and return it to the above address. Two change forms are enclosed with this notice. If a member and a spouse both have changes, you must each complete a separate form. Forms must be received in this office by October 25, 2002. If you are not adding or canceling coverage, please disregard this notice.

Cancellations

To cancel all of your TRB coverage effective January 1, 2003, the attached form must be received by October 25, 2002.

New Rates Effective January 1, 2003

Coverage Type	Per Individual
Medicare Supplement with Prescriptions	$48.00
Medicare Supplement with Prescriptions and Dental	$80.00
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$85.00

Change Opportunities

Once you enroll in a specific plan, you may NOT make any changes until the next open enrollment period, January 1, 2004, unless you are cancelling entirely out of all coverage.

Prescriptions

The annual deductible will remain at $250.00. The co-pays will remain the same.

	Mail Order	Retail
Generic	15%	20%
Preferred Brand	20%	25%
Non-Preferred Brand	30%	35%

The maximum annual out of pocket cost will remain at $2,000. Upon reaching this limit, your prescriptions will be filled at no cost to you for the remainder of the calendar year.

Dental Plan Improvement

Beginning January 1, 2003, all dental plan members will get the maximum benefit of 50% for Major Dental Services beginning with their 2nd year of coverage.

Claims/Coverages

When filing claims, please be aware that retirees and spouses enrolled in any of our plans have individual coverage. All claims should be filed as "SELF" with your own social security number regardless of whether you are the retiree or the spouse.

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Website www.state.ct.us/trb

HEALTH INSURANCE CHANGE FORM

This form is to be completed by members and spouses who are currently enrolled in a TRB Health Plan and are adding, dropping or terminating coverage.

- Submit a copy of your Medicare card even if you are currently enrolled in a Stirling & Stirling plan and wish only to change your coverage.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY OCTOBER 25, 2002.
- All changes will be effective JANUARY 1, 2003.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person Per month	**Check One(X)**
Medicare Supplement with Prescriptions	$48.00 monthly	☐
Medicare Supplement with Prescriptions and Dental	$80.00 monthly	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$85.00 monthly	☐
Cancel all TRB coverage effective January 1, 2003		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number